

# Health appraisal and medical history questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

*Please complete this form carefully. All information will be treated as strictly confidential.*

When did a physician last see you? \_\_\_\_\_

Reason: \_\_\_\_\_

May we call your Physician? YES / NO Has your physician ever advised you against exercise?  
YES/NO

If you have a physical disability, please provide the following information:

Disability: \_\_\_\_\_ Years disabled: \_\_\_\_\_

Assistive devices: \_\_\_\_\_

Movement limitations: \_\_\_\_\_

Medical precautions: \_\_\_\_\_

Are you presently receiving physical therapy? YES / NO

Reason for therapy? \_\_\_\_\_

Has your therapist ever advised you against exercise? YES / NO

## ***Medical History***

Have you ever had, or do you currently have any of the following?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Cardiac disorder                             | <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Fainting            |
| <input type="checkbox"/> Cancer                                       | <input type="checkbox"/> Chest pains            | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Dizziness                                    | <input type="checkbox"/> Phlebitis              | <input type="checkbox"/> Gout                |
| <input type="checkbox"/> Diabetes                                     | <input type="checkbox"/> Hernia                 | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Abnormal EKG                                 | <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Epilepsy            |
| <input type="checkbox"/> Heart medications                            | <input type="checkbox"/> Hypoglycemia           | <input type="checkbox"/> Kidney problems     |
| <input type="checkbox"/> Irregular heart beats                        | <input type="checkbox"/> Embolism               | <input type="checkbox"/> Pulmonary disorder  |
| <input type="checkbox"/> Numbness or tingling in<br>arms, hands, legs | <input type="checkbox"/> Respiratory infections | <input type="checkbox"/> Arthritis           |
| <input type="checkbox"/> High triglycerides                           | <input type="checkbox"/> High cholesterol       | <input type="checkbox"/> Bone fracture       |
| <input type="checkbox"/> Thyroid condition                            | <input type="checkbox"/> Nerve damage           | <input type="checkbox"/> Other medical       |
| <input type="checkbox"/> Low back pain                                | <input type="checkbox"/> Surgery                |  |
|   | <input type="checkbox"/> Emphysema              |  |

Injury to:

- |  |                                     |                                     |                                   |                               |
|--|-------------------------------------|-------------------------------------|-----------------------------------|-------------------------------|
| <input type="checkbox"/> Hip or pelvis | <input type="checkbox"/> Ankle/foot | <input type="checkbox"/> Arm/elbow  | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Face |
| <input type="checkbox"/> Knee/thigh    | <input type="checkbox"/> Back       | <input type="checkbox"/> Wrist/hand | <input type="checkbox"/> Clavicle |                               |

## Health Appraisal and Medical History Questionnaire (continued)

Please explain any items checked above: \_\_\_\_\_

Please list any other medical conditions or chronic illnesses you have or have had: \_\_\_\_\_

Do you have any conditions that limit the range of motion at any joint or in a part of your body that might be aggravated by exercise? YES / NO If yes please describe: \_\_\_\_\_

### *Health Habits History*

Do you regard yourself as being:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Overweight      | <input type="checkbox"/> Underweight           | <input type="checkbox"/> Optimal weight |
| <input type="checkbox"/> Sedentary       | <input type="checkbox"/> Moderately active     | <input type="checkbox"/> Very active    |
| <input type="checkbox"/> Unfit           | <input type="checkbox"/> Moderately fit        | <input type="checkbox"/> Very fit       |
| <input type="checkbox"/> Very stressed   | <input type="checkbox"/> Moderately stressed   | <input type="checkbox"/> Without stress |
| <input type="checkbox"/> Unhealthy       | <input type="checkbox"/> Moderately healthy    | <input type="checkbox"/> Very healthy   |
| <input type="checkbox"/> Always fatigued | <input type="checkbox"/> Occasionally fatigued | <input type="checkbox"/> Energetic      |

How many times per week do you currently engage in physical activity of at least 20 minutes duration? \_\_\_\_\_

What type of activity? \_\_\_\_\_

Have you ever attended a weight training/fitness class before? YES / NO

What are your fitness goals for this class? \_\_\_\_\_

I have answered the preceding questions to the best of my ability. I further understand that thorough and honest responses to these questions are essential to my safety and for prudent recommendations and guidance from the exercise leaders at this facility.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please return to:  
OTS - Camden Community Center  
3369 Union Ave.  
San Jose, Ca. 95124